WageWorks®
www.wageworks.com

Trinity Health Weight Management Program Claim Form

REIMBURSEMENT CLAIM FORM INSTRUCTIONS

PLEASE READ BEFORE SUBMITTING YOUR CLAIM FORM

Your colleague health plan may offer reimbursement for nutritional and/or behavioral-based counseling services for the purpose of non-surgical weight loss. These benefits are not subject to Deductible and Out-of-Pocket Maximums, but reimbursements are considered taxable income. Upon approval of your reimbursement request, benefits are payable at 100% up to a $500 annual maximum. This program reimburses for eligible activities including program fees for nationally recognized providers such as Weight Watchers® and Jenny Craig® and behavioral and/or nutritional counseling services for weight loss rendered by a Trinity Health Ministry.

Who's Eligible?

Colleagues and enrolled dependents (spouse/eligible adult and dependent children) are eligible for reimbursement of expenses incurred and paid while employed and enrolled in a Trinity Health standard medical plan including the Traditional, Health Savings and Essential plans, as well as a BCN plan.

Claim Filing Options:

- Log in to or create your account at www.wageworks.com to submit your claim electronically, or
- Fax to the Toll-Free Fax Number: (877)-353-9236, or
- Mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

What's Covered

- Outpatient counseling or therapy;
- Office visits rendered by a licensed Physician related to Weight Management;
- Lab services performed during a course of treatment related to Weight Management;
- Behavioral and/or nutritional counseling services for weight loss rendered by a Trinity Health Ministry; and
- Nationally-recognized programs that include behavioral modification and/or nutrition counseling as part of their programs such as the behavioral health and/or nutritional counseling program offered by Jenny Craig, Weight Watchers and LA Weight Loss, for the purpose of non-surgical weight loss.

What's NOT Covered

- Health clubs, gyms, personal trainers, exercise classes or exercise equipment
- Health supplements
- Fitness/sports equipment
- Claims processed through a health plan, including charges that have been applied to your Deductible and Out-of-Pocket Maximums
- Expenses submitted and reimbursed by any other health benefit plan.
- Charges for food and/or nutritional supplements
- Services or online programs administered exclusively in a Web-based forum
- Pharmacotherapy and/or injection expenses associated with weight loss
- Charges for over-the-counter diet aids
- Charges in connection with acupuncture, hypnotism, and/or biofeedback training
- Services and/or programs not approved and/or provided in the United States
- Weight Watcher Meals
- Spa memberships
- Vitamins

Reimbursements

Actively employed colleagues will receive reimbursement for approved claims in the first applicable paycheck after claims are approved. Payments can take up to three weeks after claims submission. Payment reimbursements for terminated colleagues will be delayed.

- All claims should be submitted directly to WageWorks.
- You must be employed and meet the eligibility requirements at the time you incur expenses.

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Claim Filing Options:

- **File claim online:** Log in to your account at **www.wageworks.com.**
- **Toll free Fax:** (877) 353-9236 (Fax each claim form separately to ensure quick processing.)
- **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

WW ER ID: 45396

EMPLOYEE INFORMATION

Employee Last Name

Employee First Name

ID Code (Last 4 digits)

Employer / Program Sponsor's Name: TRINITY HEALTH

Zip Code

Birth Month/Day (MM/DD)

CERTIFICATION AND AUTHORIZATION

I certify by submitting this claim that:

The information on this form is accurate and complete and that I and/or family members are currently enrolled in a Trinity Health sponsored medical plan. I am requesting reimbursement for eligible expenses incurred by myself or family member while I was a participant in this program. I have not and will not seek reimbursement for these expenses from any other program or party.

RECEIPT REQUIREMENTS

You must submit a receipt, document on Program letterhead, or any other official documentation with each claim. The following information should appear on the receipt.

(1) Colleague's or Spouse's/dependent name, (2) name of the service provider, (3) description of service, (4) payment amount (cost) and (5) payment date/period. If service date/period is not available, then payment date may be used.

OUT OF POCKET EXPENSES

DESCRIPTION OF EXPENSE OR SERVICE PROVIDER	RELATIONSHIP	DATE OF SERVICE OR PAYMENT (MM/DD/YYYY)	REQUESTED REIMBURSEMENT AMOUNT
1	Name: _____ Relationship to employee: ☐ Account holder/self ☐ Spouse ☐ Dependent child	FROM: / / TO: / /	$
2	Name: _____ Relationship to employee: ☐ Account holder/self ☐ Spouse ☐ Dependent child	FROM: / / TO: / /	$
3	Name: _____ Relationship to employee: ☐ Account holder/self ☐ Spouse ☐ Dependent child	FROM: / / TO: / /	$
		TOTAL AMOUNT THIS FORM:	$ 0

SEND A PHOTOCOPY OF YOUR RECEIPT.
KEEP ORIGINAL RECEIPT WITH A COPY OF THIS COMPLETED FORM.